FORM E: FAMILY PLANNING PROGRAM FUNDING REQUEST & PROPOSED NUMBER OF UNDUPLICATED CLIENTS

Legal Business Name: **WOMEN'S HEALTH CARE CENTER, INC**

Family Planning Program contractors may seek reimbursement for project costs using the following methods:

A. Contractors will be reimbursed using the Fee-For-Service reimbursement method by submitting claims to TMHP for direct clinical care services provided to Clients, which will then be paid by HHSC; and

B. Contractors may seek cost reimbursement for services that enhance the Fee-For-Service services provided to Clients by submitting monthly vouchers for expenses detailed in the categorical budget attached to a contractor's contract.

NOTE: Applicants may request up to 100% of their total funding request to be reimbursed through the Fee-For-Service reimbursement method or Applicants may request a portion of their funding request to be reimbursed on a cost reimbursement basis in addition to the Fee-For-Service reimbursement method. However, the cost reimbursement amount requested may not exceed 50% of Applicant's total proposed funding request and ultimately, its funding award.

Enter the amount of funds requested in the boxes below:

Fee-for-Service Amount	300,000	
Cost Reimbursement Amount	0	
Total Amount	**300,000**	

The number of Unduplicated Clients an Applicant intends to serve through the Family Planning Program will be used to assess, in part, the Applicant's effectiveness in providing the proposed services under the contract resulting from this open enrollment. This number is the estimated total number of Unduplicated Clients to whom the Applicant will provide services at the proposed clinic sites. This total should be an estimate of the number of Unduplicated Clients the Applicant proposes to serve at the Family Planning Program clinic sites included in its application. Use the following average cost per Client OR submit an explanation of the average used by the agency: **$285.00.**

Enter the estimated number of Unduplicated Clients to be served during the term of the contract, categorized by State Fiscal Year in the table below.

Period of Time	Proposed Number of Unduplicated Clients
July 1, 2016 – August 31, 2016 -- FY'16	100
September 1, 2016 – August 31, 2017 -- FY'17	952
Total Number	**1052**

Applicants must provide an explanation/justification if the average cost per Client exceeds the statewide average of $285.

FORM I: FAMILY PLANNING PROGRAM CLINIC SITES

Legal Business Name: Women's Health Care Center, INC **Clinic Site # 1_ of 1__**

CLINIC SITE INFORMATION: Complete this form for **EACH** clinic site that will provide Family Planning Program services funded under this enrollment.

Clinic Name:	**Women's Health Care Center, INC**				
Street Address:	**2914 S Buckner**			Suite:	B
City:	**Dallas**	County: **Texas**	Zip Code: **75227**	HHSR:	3
Clinic APPOINTMENT Phone #:	**214-275-5256**				
Clinic PRIMARY Phone #:	**214-275-5256**		Fax: **214-275-5284**		
Service Area *(counties to be served by this clinic site)*:	**Dallas**				
Contact Person:	Sherry Tenison				
Pharmacy License #:		Class:	Date of Pharmacy License Application Submission: 6-24-16		
TPI#:	156721606		NPI #: 1265462865		
Date of Medicaid Application Submission(if no TPI# or NPI#):					
Subcontractor Site:	☐ Yes	☒ No			
Mobile Site:	☐ Yes	☒ No			

CLINIC HOURS

DAY	HOURS OF OPERATION					
	Morning		Afternoon		Evening (after 5pm)	
	From	To	From	To	From	To
MONDAY	9	1	2	5		
TUESDAY	9	1	2	5		
WEDNESDAY	9	1	2	5		
THURSDAY	9	1	2	5		
FRIDAY	9	1	2	5		
SATURDAY	9	12				
SUNDAY	Closed					

Texas Health and Human Services Commission
Vendor Information Form (VIF)

Instructions: This form must be completed and submitted with **each** new contract, amendment, renewal, and/or extension.
(Please type or print information.)

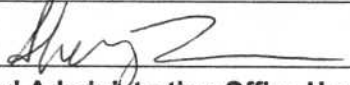
SECTION 1: Contractor's General Information

Legal Contractor's Name:	Women's Health Care Center, Inc		
Legal Doing Business As (DBA) Name:	Women's Health Care Center, Inc		
Physical Address:	2914 S BUCKNER STE B DALLAS TEXAS 75227		
Remit To (Payment) Address:	2914 S BUCKNER STE B DALLAS TEXAS 75227		
Enter Texas Identification Number (TIN)	Texas Identification Number (TIN): -943432832 (11 digit TIN must be provided) **(Contact Accounts Payable at Vendor@hhsc.state.tx.us for valid 11 digit TIN (if unknown)**		
Select the Legal Status:	☐ For-profit Entity	☒ Non-profit Entity	
Select the Business Structure:	☒ Corporation ☐ Joint Venture ☐ Partnership* ☐ Limited (Liability) Company ☐ Limited (Liability) Partnership ☐ Sole Proprietorship ☐ Governmental Entity (must specify): _____ ☐ Other (must specify): _____ * If Partnership, must provide SSN or TIN for minimum of two partners		
	Partner Name: _____	TIN : _____	
	Partner Name: _____	TIN : _____	
If applicable, enter appropriate information:	State of Incorporation: TEXAS	Texas Charter Number: _____	Name of Parent Entity: _____

SECTION 2: Contractor's Contact Information

Person Who Will Sign the Contract		Point of Contact for Contract	
Name:	SHERRY TENISON	Name:	SHERRY TENISON
Title:	EXECUTIVE OFFICE	Title:	EXECUTIVE DIRECTOR
Mailing Address:	2914 S BUCKNER	Mailing Address:	2914 S BUCKNER STE B
Telephone:	214-275-5256	Telephone:	214-275-5256
Fax:	214-275-5284	Fax:	214-275-5284
E-mail:	SHERRYTENISON@YAHOO.COM	E-mail:	SHERRYTENISON@YAHOO.COM

SECTION 3: Contractor's Authorized Signature (or HHSC Contract Manager)

Printed Name	Signature	Date	Phone Number
SHERRY TENISON		8/1/2016	214-703-6527

SECTION 4: ECPS Contract and Administration Office Use Only

Contractor to Receive Payment: ☐ No ☐ Yes	
Contract Number:	

FORM A: FACE PAGE

This form requests basic information about the Applicant and project, including the signature of the authorized representative. The face page must be completed in its entirety.

APPLICANT INFORMATION

1) **LEGAL BUSINESS NAME:** WOMEN'S HEALTH CARE CENTER, INC.

2) **MAILING Address Information** (include mailing address, street, city, county, state and zip code):
2914 S BUCKNER STE B DALLAS TEXAS 75227

3) **PAYEE Name and Mailing Address** (if different from above):

4) **DUNS Number** (9-digit): 829195259

5) **Health and Human Service Region:** 3

6) **Federal Tax ID No.** (9 digit), **State of Texas Comptroller Vendor ID No.** (14 digit) or **Social Security Number** (9 digit): 943432832

**The Applicant acknowledges, understands and agrees that the Applicant's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.*

7) **TYPE OF ENTITY** (check all that apply):

- ☐ City
- ☐ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☒ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Faith Based (Nonprofit Org)
- ☐ Individual
- ☐ Federally Qualified Health Centers
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

**If incorporated, provide 10-digit charter number assigned by Secretary of State:* 0800987809

8) **BUDGET PERIOD:** **Start Date:** July 1, 2016 **End Date:** August 31, 2017

9) **COUNTIES SERVED BY FAMILY PLANNING PROJECT:** (complete Form C:Texas Counties and Regions) DALLAS

10) **PRIMARY PLACE OF SERVICES PROVIDED** 2914 S BUCKNER STE B DALLAS TEXAS 75227

11) **TOTAL FUNDING REQUESTED:** 300,000

Fee for Service: $300,000 | Categorical: 0

12) **PROJECTED EXPENDITURES**

Does Applicant's projected federal expenditures exceed $500,000, or its projected state expenditures exceed $500,000, for Applicant's current fiscal year (excluding amount requested in line 9 above)? **

Yes No X

***Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.*

13) **FAMILY PLANNING (FP) PRIMARY CONTACT PERSON**
Name: SHERRY TENISON RN, EXECUTIVE DIRECTOR
Phone: 214-275-5256
Fax: 214-275-5284
EmailSHERRYTENISON@YAHOO.COM

14) **FINANCIAL OFFICER**
Name:
Donnie
Graham
Phone 214
Fax:214-
275-
5284
Email:Do
nnie
Graham
@

The facts affirmed by me in this proposal are truthful and I warrant the Applicant is in compliance with the assurances and certifications contained in **APPENDIX I: HHSC Assurances and Certifications**. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the Applicant and I (the person signing below) am authorized to represent the Applicant.

15) AUTHORIZED REPRESENTATIVE

Name: Sherry Tenison RN Executive Director
Title: Executive Director

16) SIGNATURE OF AUTHORIZED REPRESENTATIVE

17) DATE 8/1/2016

Phone: 214-275-5256
Fax: 214-275-5284
Email: sherrytenison@yahoo.com

8-1-2016